	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
ANDILANC	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMIL	-120
		004608	B. WING		07/2	9/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
VNA HEAL	THTRENDS	732 E US F	IWY 30 VILLE, IN 4637	75		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
N 000	Initial Comments		N 000			
	This was a home hea	Ith state relicensure survey.				
	Survey date: 7/23/14	- 7/29/14				
	Facility # 004608					
	Medicaid # 20053874	0				
	Surveyors: Ingrid Mil Surveyor	ler, RN, PHNS, Lead				
	Susan E. S	Sparks, RN, MAE, PHNS				
	507 skilled unduplicat	ted patients for past year				
	Quality Review: Joyce August 5, 20	e Elder, MSN, BSN, RN 114				
N 456	410 IAC 17-12-1(e) Hadministration/manag	- ·	N 456			
	responsible for an one program designed to (1) Objectively and s	ystematically monitor and nd appropriateness of problems.				
	agency failed to ensu assurance program we evaluate the quality a	review and interview, the re the ongoing quality ras designed to objectively and appropriateness of lidentified problems, and				

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SI	
			A. BOILDING			
		004608	B. WING		07/2	9/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
VNA HEAL	THTRENDS	732 E US		-		
	CLIMMADY CT		RVILLE, IN 4637			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
N 456	Continued From page	e 1	N 456			
N 458	president of operation assurance program unclinical records. The There are daily electrodocuments sent to state regarding oasis quest assurance program. Agency. There was massurance program. 2. A review of agency evidence a quality as	Chart review is done in the to written plan for the quality by documents failed to surance program that problems and improved	N 458			
	Rule 12 Sec. 1(f) Per employees shall be so All employees caring be subject to Indiana registration required the service. Personnel redeliver home health so and shall include doct the job, including the (1) Receipt of job de (2) Qualifications. (3) A copy of limited IC 16-27-2. (4) A copy of current registration. (5) Annual performant.	ersonnel practices for upported by written policies. for patients in Indiana shall licensure, certification, or o perform the respective ecords of employees who services shall be kept current umentation of orientation to following: escription. criminal history pursuant to the license, certification, or once evaluations.				

Indiana State Department of Health

STATE FORM 6899 KEP411 If continuation sheet 2 of 26

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		004608	B. WING		07/20/2044	
NAME OF P	ROVIDER OR SUPPLIER		PRESS, CITY, STA	TE ZIP CODE	07/29/2014	
		732 E US F		12, 211 GGBE		
VNA HEAI	_THTRENDS	SCHERER	VILLE, IN 4637	75		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPL	ETE
N 458	Continued From page	2	N 458			
	interview, the agency personnel policies we employee records rev , R).					
	Findings					
	hire 3/10/14 and first	pational therapist, date of patient contact 3/10/14, bb description had been				
	2/1/13 and first patier	e health aide, date of hire at contact 2/25/13, failed to d been verified as in good aide registry.				
	5/22/14 and first patie evidence a job descr the time of hire. The	e health aide, date of hire ent contact 6/11/14, failed to iption had been signed at file also evidenced the I not been verified as in state aide registry.				
		•				
	3/1/13 and first patier	e health aide, date of hire at contact 3/2/13, failed to deen verified as in good aide registry.				
	6. On 7/29/14 at 4:05 PM, Employee V, human resources, indicated the personnel files were not complete.					
		titled "Employee Handbook" ber 2012 stated, "The				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		004608	B. WING		07	//29/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
VNA HEA	LTHTRENDS		S HWY 30 ERVILLE, IN 46375			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 458	providers staff who or certification in order necessary credentials annually Additional reviews are conducted anniversary date annually Additional reviews are conducted anniversary date annually Additional reviews are conducted anniversary date annually The agency policy a date of June 2012 stage description for each of qualifications, defines responsibilities." 9. The agency policy Performance Apprais stated, "Agency staff evaluation after 90 dates to comply with gove 10. The agency policy review date of June 2 will be provided to clinic compliance with fereign and stage to compliance to	ten competencies for field of must have a licensure and / er to provide proof of s at the time of hire and I formal performance ed on the employee qually." Ititled "Job descriptions" with stated, "There will be a job employee position that states is roles, and list Ititled "Employee evaluation eal" with a date of June 2012 may receive a written ays as indicated and annually	N 458			
N 470	410 IAC 17-12-1(m) I administration/manag	Home health agency gement	N 470			
	be written and impler					
	Based on observation policies and procedure	n, interview, and review of res, the agency failed to rses (RN) provided services				

Indiana State Department of Health

STATE FORM 6899 KEP411 If continuation sheet 4 of 26

indiana S	state Department of He	eaith				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
		004608	B. WING		07/2	29/2014
					1 0112	.9/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
VNA HEAI	LTHTRENDS	732 E US	HWY 30			
		SCHERE	RVILLE, IN 4637	75		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
IAG			IAG	DEFICIENCY)		
N. 470	0 " 15		N 470			
N 470	Continued From page	e 4	N 470			
	in accordance with ag	gency policy in 2 of 2 home				
	visit observations (Pa	atients #4 and #6) with a				
	registered nurse (Em	ployee I and Employee P).				
	The findings include					
	1. On 7/25/15 at 7 Al	M, Employee P, RN, was				
		es and remove the wound				
	•	# 4's abdominal wound and				
		He did not remove his				
		g the old dressing or wash				
		proceeded to clean the				
	-	y the clean dressing for the				
		. He discarded all supplies				
		es and then washed his				
	hands.					
	2. On 7/25/14 at 9 A	M, Employee I, RN, was				
	observed at a home v	visit with patient #6.				
	Employee I was obse	erved to wash her hands and				
	don clean gloves and	I then place all dressing				
	supplies on the patier	nt's living room floor. There				
		en these supplies, which				
	included a Genadyne	Foam Kit Thin Medium, 4				
	gauze dressings, clea	an gloves, skin preparation				
	pad, and a saline was	sh bottle, and the floor. She				
	removed the old dres	sing from the patient's left				
	foot and discarded he	er gloves. She did not wash				
	her hands. She appli					
	dressed the wound a	nd applied the wound vac.				
	0 -					
		titled "Hand hygiene" with a				
		2012 stated, "Field providers				
	will wash hands af	ter removing soiled gloves."				
	4. The agency policy	titled "Standard				
		evised date of June 2012				
		g with an antibacterial soap,				
		tizer will be done before				
		gloves; B. upon removal of				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		004608	B. WING		07	//29/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
VNA HEA	LTHTRENDS		S HWY 30 ERVILLE, IN 46375			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 470	technique" with a rev stated, "The floor is a open bag and rem a clean work area wit	titled "Bag contents and ised date of June 2012 grossly contaminated area ove supplies. Place them on h appropriate barrier paper vation, interview, and review	N 470			
N 472	develop, implement, quality assessment a improvement program the complexity of the and services (including directly or under arrangency must take act improvements in the performance across thome health agency performance improve objective measures. This RULE is not measured agency failed to ensure assurance program we valuate the quality apatient care, resolved improve patient care.	the home health agency must maintain, and evaluate a and performance in. The program must reflect home health organization ag those services provided agement). The home health cions that result in shome health agency's he spectrum of care. The sequality assessment and ment program must use that as evidenced by: review and interview, the are the ongoing quality was designed to objectively and appropriateness of a identified problems, and for 1 of 1 agency.	N 472			
		PM, Employee B, vice				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		004608	B. WING		07/29/2014
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
VNA HEAL	THTRENDS	732 E US SCHERE	HWY 30 RVILLE, IN 4637	75	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
N 472	Continued From page	e 6	N 472		
	clinical records. The There are daily electr documents sent to staregarding oasis quest assurance program. agency. There was reassurance program. 2. A review of agency evidence a quality as	Chart review is done in the no written plan for the quality			
N 484	410 IAC 17-12-2(g) Comprovement	A and performance	N 484		
	Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.				
	and interview, the age personnel communica services to support th 10) of 12 records revi	ord and agency policy review ency failed to ensure all			
	The findings include				
		7, start of care 6/21/14, re for the certification period			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _		COMIL	LILD
		004608	B. WING		07/2	9/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
VNA HEAI	LTHTRENDS	732 E US				
	OUR MARK OT	ATEMENT OF DEFICIENCIES	RVILLE, IN 463			
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
N 484	Continued From page	e 7	N 484			
N 484	of 6/21/14 - 8/19/14 whoursing, occupational therapy. The clinical any coordination of cathese services to supcare. Skilled nursing 6/25/14, 7/1/14, 7/4/1 7/22/14. Occupationa 6/27/14, 7/2/14, 7/9/14, 7/9/14, 7/9/14, 7/9/14, 7/9/14, 7/9/14 and 7/18/14. On 7/28/14 at 12 president of operation coordination of care be caring for the patient. 2. Clinical record #10 included a plan of care be caring for the patient. 2. Clinical record #10 included a plan of care of 5/3/14 - 7/1/14 with therapy and physical documentation to show and occupational therand coordinated serviplan of care. Physical 5/3/14, 5/8/14, 5/14/1 Occupational therapy 5/15/14, 5/17/14, 5/18/15/31/14. On 7/28 at 4:50 Fit there was no coordinated services caring for this 3. The agency policy	with orders for skilled therapy and physical record failed to show that are had occurred between port the patient's plan of visits were on 6/21/14, 4, 7/8/14, 7/15/14, and al therapy visits were on 4, 7/18/14, and 7/19/14. s were on 7/23/14, 6/25/14, 7/11/14, 7/15/14, 7/16/14,:30 PM, Employee B, vice as, indicated there was no between these services. O, start of care 5/3/14, fe for the certification period a orders for occupational therapy. There was no low that the physical therapist rapist had communicated fices to support the patient's all therapy visits occurred on 4, 5/17/14, 5/24/14. Visits occurred on 5/9/14, 2/14, 5/22/14, 5/30/14, and PM, Employee B indicated ation of care between the	N 484			
	be assigned to coordi	oist, or speech therapist will nate the care of each client charge. This RN, PT, or ST				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
		004608	B. WING		07/29/2014
					07/29/2014
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE	
VNA HEAL	THTRENDS		S HWY 30 ERVILLE, IN 46375		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 484	Continued From page	8	N 484		
	care team's communi	coordination of the home cation and the client's plan with government regulations ty of care; to assure			
N 518	410 IAC 17-12-3(e) P	atient Rights	N 518		
	distribute written infor advance, concerning directives, including a state law. The home advanced directives in the time of the first ho information is furnished. This RULE is not mediased on clinical reconstruction agency document revensure patients were Advanced Directives,	ord review, interview, and iew, the agency failed to			
	Findings include				
	failed to include the errevised July 1, 2013, directives in the admis	ok given to the patients ffective May 2004 and state of Indiana advanced ssion folder that was ents at the start of care			
	operations, Employee directives were not the	PPM, the vice president of B, indicated the advanced e effective and current ectives (effective May 2004			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		004608	B. WING		07/29	9/2014
	ROVIDER OR SUPPLIER	732 E US	DDRESS, CITY, STA HWY 30 RVILLE, IN 4637			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
N 518	and revised July 1, 20 home admission bool agency needed to red directives. 3. Clinical record #1, contain an updated J 2004 Indiana Advance The patient signed the received on the SOC 4. Clinical record #2, contain an updated J 2004 Indiana Advance The patient signed the received on the SOC 5. Clinical record #3, contain an updated J 2004 Indiana Advance The patient signed the received on the SOC 6. Clinical record #4, contain an updated J 2004 Indiana Advance The patient signed the received on the SOC 7. Clinical record #5, contain an updated J 2004 Indiana Advance The patient signed the received on the SOC 7. Clinical record #5, contain an updated J 2004 Indiana Advance The patient signed the received on the SOC 8. Clinical record #6, contain an updated J	SOC 7/2/14, failed to uly 1, 2013, version of the ed Directives document. at the document was date. SOC 7/5/14, failed to uly 1, 2013, version of the ed Directives document. at the document was date. SOC 7/10/14, failed to uly 1, 2013, version of the ed Directives document. at the document was date. SOC 7/5/14, failed to uly 1, 2013, version of the ed Directives document. at the document was date. SOC 7/2/14, failed to uly 1, 2013, version of the ed Directives document. at the document was date. SOC 7/19/14, failed to uly 1, 2013, version of the ed Directives document. at the document was date. SOC 7/19/14, failed to uly 1, 2013, version of the ed Directives document. at the document was date. SOC 7/12/14, failed to uly 1, 2013, version of the ed Directives document. at the document was date.	N 518			

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received on the SOC date.

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		
		004608	B. WING		07	//29/2014
	PROVIDER OR SUPPLIER	732 E U	ADDRESS, CITY, STATE S HWY 30	ZIP CODE	·	
		SCHERI	ERVILLE, IN 46375			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 518	Continued From page	e 10	N 518			
	contain an updated J 2004 Indiana Advance The patient signed the received on the SOC 10. Clinical record #8 contain an updated J 2004 Indiana Advance The patient signed the received on the SOC 11. Clinical record #9 contain an updated J 2004 Indiana Advance The patient signed the received on the SOC 11. Clinical record #9 contain an updated J 2004 Indiana Advance The patient signed the received on the SOC 11.	date. 3, SOC 1/28/14, failed to uly 1, 2013, version of the ed Directives document. at the document was date. 9, SOC 11/14/13, failed to uly 1, 2013, version of the ed Directives document. at the document was				
	contain an updated J	uly 1, 2013, version of the ed Directives document. at the document was				
	contain an updated J					
	contain an updated J					
	Indiana Law on Adva	ument titled "Statement of nce Directives" with no "The Statement of Indiana				

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Indiana State Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		004608	B. WING		07/29/2014	
	ROVIDER OR SUPPLIER	732 E US I	DRESS, CITY, STA HWY 30 VILLE, IN 4637			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
N 518	fulfillment of the Omn Act of [Obra '90] requ prepare such a stater providers It is agen rights of its clients to	ctives has been written in ibus Budget Reconciliation irement that the State nent to be distributed by acy's policy to recognize the make informed decisions are it is our policy to	N 518			
N 522	22 410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:		N 522			
	This RULE is not met as evidenced by: Based on clinical record review, policy review, observation, and interview, the agency failed to ensure care visits and treatments were provided as ordered on the plan of care for 5 of 12 records reviewed (#3, #4, #6, #7, #10).					
	and diagnosis of nonlincluded a plan of car of 7/5/14 - 9/2/14 with visit four times a wee week for 2 weeks, 1 t and 1 time every 2 we to report a pattern of 350 milligram / dl. Tho finterventions for the	start of care (SOC) 7/5/14 nealing surgical wound, re for the certification period n orders for skilled nursing to k for one week, 3 times a time a week for two weeks, eeks. The skilled nurse was blood glucose levels over here was no documentation the patient to keep track of the ty by day. The skilled nurse				

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		004608	B. WING		07	//29/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
VNA HEA	LTHTRENDS	732 E US SCHERE	HWY 30 RVILLE, IN 46375			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 522	surgical wound three wound cleanser, pat of Cover with dry gauze secure with kerlix and At visits on 7/5/14, 7/17/14/14, 7/16/14, 7/19 nurse used telfa to drailed to evidence and dress the wound. On 7/24/14 at 3:4 president of operation was not taught to kee telfa was not ordered 2. Clinical record #4, of nonhealing surgical care for the certification with orders for skilled week for one week, 3 and 2 times a week for nurse was to provide of diabetic care to incoming ucose testing and the pattern of blood glucomy / dl [milligram / de documentation of interest with orders for the blood of the patient should have blood sugar log to show for this patient. 3. Clinical record #6, of nonhealing surgical care for the certification with orders for skilled with orders for skilled	of wound car to left foot times a week, cleanse with dry. Apply iodoform packing. and abdominal pad. Then I tape using clean technique. 19/14, 7/11/14, 7/12/14, 19/14, and 7/21/14, the skilled less the wound. The record order for Telfa to be used to 140 PM, Employee B, vice instance in the patient on the plan of care. 19/14 and diagnosis I wound, included a plan of the priod of 7/2/14 - 8/30/14 included in the plan of control of the plan of the plan of control of the plan of control of the plan of the plan of the plan of control of the plan of the plan of the plan of control of the plan	N 522			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING: COMPL		E SURVEY PLETED	
		00.4509	B. WING		0-	7/00/0044
		004608			1 0/	7/29/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
VNΔ Η Γ Δ	LTHTRENDS	732 E US	HWY 30			
VIVA II EA	LITTICENDO	SCHERE	RVILLE, IN 46375			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 522	Continued From page	e 13	N 522			
	1 week. The skilled r wound with wound wa green vac foam, appl transparent drape, ap mm [millimeter] contin	eeks, and 1 times a week for nurse was to cleanse the ash, fill the entire cavity with y tubing and cover with oply wound vac device at 125 nuous. Apply dressing every d have been three times a				
	Employee I, was obsoured tressing by filling foam, cover with transtubing. After applying the extra green foam dressing and tubing.	AM, the registered nurse, erved to apply the wound in the wound cavity with green sparent drape and apply go the tubing, the nurse added to cushion the wound vachere was no order for an over the transparent drape				
	of surgical hip repair, the certification period orders for the home has week for two weeks a for two weeks. The athe first week on 6/25 second week on 7/3/orders for the occupatimes a week for one week for three weeks therapist to visit 1 times then two times a week therapist only made of second week). The orders for the second week).	SOC 6/21/14 and diagnosis included a plan of care for d of 6/21/14 - 8/19/14 with health aide to visit 2 times a and then one times a week hide during visited only once 6/14 and only once the 14. The plan of care had tional therapist to visit one week and then two times a sand orders for the physical es a week for one week and k for 5 weeks. The physical one visit on July 2nd (the occupational therapist only y 12th (the third week).				
	indicated the home h	::30 PM, Employee B eath aide, occupational al therapist did not visit of care.				

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Indiana State Department of Health

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
		004608	B. WING		07/29/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE	
VNΔ ΗΕΔ	LTHTRENDS	732 E US	HWY 30		
VIVATILA	LITTINENDO	SCHERE	RVILLE, IN 46375		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 522	Continued From page	: 14	N 522		
	of other specified rehall generalized muscle will disorder, and unspecified rehall generalized muscle will disorder, and unspecified included a plan of cart therapy orders 1 times times a week for one and occupational thereweek and two times a physical therapist visit 5/14/14, 5/24/14. The visited on 5/9/14, 5/15/5/22/14, 5/30/14, and therapist failed to visit week of 5/11/14 - 5/17/17/17/19/19/19/19/19/19/19/19/19/19/19/19/19/	reakness, depressive fied peripheral vertigo, e with orders for physical is a week for 2 weeks, 2 week, and 1 times a week apy orders for 1 times a week for three weeks. The sted on 5/3/14, 5/8/14, e occupational therapist 5/14, 5/17/14, 5/19/14, 5/31/14. The physical is the patient twice during the 7/14.			
	with a date of June 20 treatments will be adn provider as ordered by	titled "Physician's orders" 012 stated, "Medications and ninistered by agency field y a licensed physician all led in compliance with state ations."			
	date of June 2012 sta services are provided supervision of a physicare that is established by the physician to endoff services to the clien the provision of quality home health care services are provided general supervision of	titled "Plan of Care" with a ted, "Home health care under the general cian, based on a plan of ed and periodically reviewed usure appropriate application in the condition in the condition in the condition in the condition in the part of the care to clients a. under the faphysician b. based on a ablished and periodically			

Indiana State Department of Health

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Indiana S	tate Department of He	alth				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLE	
7.1.1.2.1.2.1.1.1		ISENTI IS THE TOTAL OF THE PARTY OF THE PART	A. BUILDING: _		"	
		004608	B. WING		07/2	9/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
VNA HFAI	_THTRENDS	732 E US	HWY 30			
		SCHERE	RVILLE, IN 4637	75		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
N 522	Continued From page	: 15	N 522			
	reviewed by physiciar application of the serv	n to ensure appropriate vices to condition."				
N 524	410 IAC 17-13-1(a)(1) Patient Care	N 524			
	of care shall: (A) Be developed in the chealth agency staff. (B) Include all services service is being provide (B) Cover all pertiner. (C) Include the follow. (i) Mental status. (ii) Types of services. (iii) Frequency and of (iv) Prognosis. (v) Rehabilitation pour (vi) Functional limitation. (vii) Activities permitation. (viii) Nutritional requires. (ix) Medications an (x) Any safety meaning injury. (xi) Instructions for	at diagnoses. Fing: Ses and equipment required. Solution of visits. Solutions. Sted. Fements. d treatments. Issures to protect against stimely discharge or referral. Sies specifying length of				
	This RULE is not me	t as evidenced by: ord review, interview, and				

Findings

policy review, the agency failed to ensure the plan of care included all the required elements in 4 of 12 records reviewed (#1, 2, 6, 8) with the potential to affect all the patients of the agency.

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED
			A. BOILDING.			
		004608	B. WING		07	//29/2014
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VNΔ ΗΕΔ	LTHTRENDS	732 E US	S HWY 30			
VIVATILA	LITTIKENDS	SCHERE	RVILLE, IN 46375			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 524	Continued From page	e 16	N 524			
	and diagnosis of unspecllulitis, and esophage evidence an individual certification period of of care included order instruct safe transfers chair, and commode) mechanics and equip lift, trapeze, bath benepatient's plan of care had a cane, shower / and did not have a slit trapeze, and / or when plan of care did not acceptance of care did not ac	geal reflux, failed to lized plan of care for the 7/2/14 - 8/30/14. The plan rs for physical therapy to (bed, bath, toilet, sofa, using appropriate body ment (sliding board, Hoyer ch, wheelchair). The evidenced that the patient tub equipment, and walker ding board, Hoyer lift, elchair. The goals for this ddress care for this patient shageal reflux diagnosis. 45 PM, Employee B, vice is, indicated the plan of care d and no goals addressed				
	of after care of hip repevidence that the plar period of 7/10/14 - 9/7 patient's durable med patients CPAP machineach night. The plan an individualized plan for physical therapy to (bed, bath, toilet, soft using appropriate boolequipment (sliding bobench, wheelchair). Tevidenced that the par	n of care for the certification 7/14 that included all the ical equipment including the ne that the patient used of care failed to evidence of care. There were orders instruct safe transfers a, chair, and commode) by mechanics and ard, Hoyer lift, trapeze, bath the patient's plan of care tient had a cane, shower / ralker and did not have a				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE COMI	SURVEY PLETED
		004608	B. WING		07	/29/2014
	ROVIDER OR SUPPLIER	732 E US	DDRESS, CITY, STATE S HWY 30 ERVILLE, IN 46375	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
N 524	Continued From page On 7/24/14 at 9:2	e 17 20 AM, patient #2 indicated	N 524			
	using a CPAP machir apnea and using a ca transferring.	e each night for sleep ne and walker for				
	of nonhealing surgical care for the certification 9/9/14. This plan of contacted, "Skilled nurse	SOC 7/12/14 and diagnosis I wound, included a plan of on period of 7/12/14 - are included an order that to cleanse wound with re cavity with green vac				
	foam. Apply tubing a drape. Apply wound	nd cover with transparent vac at 125 mm [millimeters] Change dressing every 48				
	the correct order wou	AM, Employee B indicated ld be to change the wound nes a week not every 48				
	of congestive heart fa for the certification pe with a physician's sign	SOC 1/28/14 and diagnosis ilure, included plans of care riods of 1/18/14 - 3/28/14 nature of 3/14/14 and a 5/28/14 - 7/16/14 with a on 7/2/14.				
		PM, Employee B indicated ures were late on these				
	date of June 2012 sta are provided under th physician, based on a established and perio physician to ensure a	titled "Plan of care" with a te, "Home Health services e general supervision of a plan of care that is dically reviewed by the ppropriate application of s condition. Purpose to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		004608	B. WING		07/29/2014
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 01123/2014
VNA HEAI	_THTRENDS	732 E US H			
		SCHERER	VILLE, IN 4637	' 5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
N 524	Continued From page	e 18	N 524		
	ensure the provision of approved home health client's plan of care is consultation with field following type of he required client's tree	of quality and legally h care services The developed by a physician in providers B. includes the me health care services eatment client's permitted in and therapy services pliances necessary			
N 537	410 IAC 17-14-1(a) S	cope of Services	N 537		
	provide nursing servic a licensed practical no medical plan of care a				
	observation, and interesting ensure care by the re	ord review, policy review, rview, the agency failed to gistered nurse was provided n of care for 3 of 12 records			
	Findings				
	and diagnosis of nonlincluded a plan of car of 7/5/14 - 9/2/14 with visit four times a week week for 2 weeks, 1 ti and 1 time every 2 we to report a pattern of 1350 milligram / dl. The of interventions for the	start of care (SOC) 7/5/14 nealing surgical wound, re for the certification period norders for skilled nursing to k for one week, 3 times a time a week for two weeks, the skilled nurse was blood glucose levels over there was no documentation the patient to keep track of the ty by day. The skilled nurse			

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Indiana State Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 732 E US HWY 30 SCHERERVILE, IN 48375 MAJID PREPIX SUMMARY STATEMENT OF DEFICIENCES PREPIX RECOULTIVE OF INCIDENCY MUST BE PRECEDED BY TULL PREPIX RECOULTIVE OF INCIDENCY MUST BE PRECEDED BY TULL PREPIX TAQ N 537 Continued From page 19 Caregiver procedure of wound car to left foot surgical wound three times a week, cleanse with wound cleanser, pad 19, Apply lodoform packing. Cover with dry gauze and abdominal pad. Then secure with kerlix and lagar dry. Apply lodoform packing. Cover with dry gauze and abdominal pad. Then secure with kerlix and raped 1714, 171214, 171614, 71914, and 7/2114, the skilled nurse used telfa to dress the wound. On 7/24/14 at 3.40 PM, Employee B, vice president of operations, indicated that the patient was not taught to keep a blood sugar log and that telfa was not ordered on the plan of care. 2. Clinical record #4, SOC 7/2/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/24/14 - 3/30/14 with orders for skilled nurse was to provide instructions / reinforcement of diabetic care to include delict, skin care, blood glucose testing and the skilled nurse was to provide instructions / reinforcement of diabetic care to include delict, skin care, blood glucose testing and the skilled nurse to report a pattern of blood glucose levels greater than 250 mg /d Imiligram / decliter). There was no documentation of interventions for the patient to keep track of the blood sugar levels day by day. On 7/24/14 at 4-0.5 PM, Employee B indicated the patient should have been instructed to keep a blood sugar log to show the blood sugar patterns for this patient.		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		' '	E SURVEY PLETED
TAGE CAN 10 PREFIX TAGE TA			004608	B. WING		07	7/29/2014
VAN HEALTHTRENDS SUMMARY STATEMENT OF DEFICIENCIES DEPERT CREATE PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROWNERS PRECEDED BY PULL TAG PREFIX TAG CROSS REFERENCED BY PULL TAG CROSS REFERENCE ACTION SHOULD BE CROSS REFERENCE TO THE APPROPRIATE DATE	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE	,	
NSHERVILLE, IN 48376 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE	\/\\\ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	TUTDENDO	732 E US	HWY 30			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) N 537 Continued From page 19 caregiver procedure of wound car to left foot surgical wound three times a week, cleanse with wound cleanser, pat dry. Apply iodoform packing. Cover with dry gauze and abdominal pad. Then secure with kerlix and tape using clean technique. At visits on 7/5/14, 7/9/14, 7/11/14, 7/11/14, 7/11/14, 7/11/14, 7/11/14, 7/19/14, and 7/2/11/4, the skilled nurse used telfa to dress the wound. On 7/2/14 at 3:40 PM, Employee B, vice president of operations, indicated that the patient was not taught to keep a blood sugar log and that telfa was not ordered on the plan of care. 2. Clinical record #4, SOC 7/2/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/2/14 - 8/30/14 with orders for skilled nurse was to provide instructions / reinforcement of diabetic care to include diet, skin care, blood glucose testing and the skilled nurse was to provide instructions / reinforcement of diabetic care to include diet, skin care, blood glucose testing and the skilled nurse to report a pattern of blood glucose levels greater than 250 mg / dl [milligrant / deciliter]. There was no documentation of interventions for the patient to keep track of the blood sugar levels day by day. On 7/24/14 at 4:05 PM, Employee B indicated the patient should have been instructed to keep a blood sugar log to show the blood sugar patterns for this patient.	VNA HEAI	LIHIRENDS	SCHERE	RVILLE, IN 46375			
caregiver procedure of wound car to left foot surgical wound three times a week, cleanse with wound cleanser, pat dry. Apply iodoform packing. Cover with dry gauze and abdominal pad. Then secure with kerlix and tape using clean technique. At visits on 7/5/14, 7/9/14, 7/11/14, 7/12/14, 7/14/14, 7/16/14, 7/19/14, and 7/21/14, the skilled nurse used telfa to dress the wound. The record failed to evidence an order for Telfa to be used to dress the wound. On 7/24/14 at 3:40 PM, Employee B, vice president of operations, indicated that the patient was not taught to keep a blood sugar log and that telfa was not ordered on the plan of care. 2. Clinical record #4, SOC 7/2/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/2/14 - 8/30/14 with orders for skilled nursing to visit 2 times a week for one week, 3 times a week for 5 weeks, and 2 times a week for 3 weeks. The skilled nurse was to provide instructions / reinforcement of diabetic care to include diet, skin care, blood glucose testing and the skilled nurse to report a pattern of blood glucose levels greater than 250 mg / dl [milligram / deciliter]. There was no documentation of interventions for the patient to keep track of the blood sugar levels day by day. On 7/24/14 at 4:05 PM, Employee B indicated the patient should have been instructed to keep a blood sugar log to show the blood sugar patterns for this patient.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETE
3. Clinical record #6, SOC 7/12/14 and diagnosis of nonhealing surgical wound, included a plan of care for the certification period of 7/12/14 - 9/9/14	N 537	caregiver procedure of surgical wound three wound cleanser, pat of Cover with dry gauze secure with kerlix and At visits on 7/5/14, 7/5 7/14/14, 7/16/14, 7/	of wound car to left foot times a week, cleanse with dry. Apply iodoform packing, and abdominal pad. Then I tape using clean technique. 19/14, 7/11/14, 7/12/14, 19/14, and 7/21/14, the skilled less the wound. The record order for Telfa to be used to 19/14. The patient period of the patient on the plan of care. SOC 7/2/14 and diagnosis I wound, included a plan of the particular on the plan of the patient on period of 7/2/14 - 8/30/14 nursing to visit 2 times a times a week for 5 weeks, or 3 weeks. The skilled instructions / reinforcement lude diet, skin care, blood the skilled nurse to report a the see levels greater than 250 ciliter]. There was no the reventions for the patient to the disagrar levels day by day. SOC 7/12/14 and diagnosis I wound, included a plan of sociological patterns.	N 537			

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION	(X3) DATE SU COMPLET		
		004608	B. WING		07/29	/2014
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VNA HEA	LTHTRENDS		RVILLE, IN 46375			
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N 537	Continued From page	e 20	N 537			
	1 week. The skilled r wound with wound we green vac foam, appl transparent drape, ap mm [millimeter] contil	eeks, and 1 times a week for nurse was to cleanse the ash, fill the entire cavity with y tubing and cover with oply wound vac device at 125 nuous. Apply dressing every d have been three times a				
	Employee I, was obsoured tressing by filling foam, cover with transtubing. After applying the extra green foam dressing and tubing.	AM, the registered nurse, erved to apply the wound go the wound cavity with green sparent drape and apply go the tubing, the nurse added to cushion the wound vac. There was no order for an over the transparent drape				
	with a date of June 2 treatments will be add provider as ordered by	titled "Physician's orders" 012 stated, "Medications and ministered by agency field by a licensed physician all ned in compliance with state ations."				
	date of June 2012 sta services are provided supervision of a phys care that is establishe by the physician to er of services to the clie the provision of qualit home health care ser services are provided general supervision of client plan of care est	ician, based on a plan of ed and periodically reviewed insure appropriate application int's condition to ensure ty and legally approved vices home health care if to clients a. under the of a physician b. based on a tablished and periodically in to ensure appropriate				

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Indiana State Department of Health

A BUILDING: O04608 A BUILDING: D729/2014 NAME OF PROVIDER OR SUPPLIER TAGE SUMMARY STATEMENT OF DEPICIENCIES TAGE SUMMARY STATEMENT OF DEPICIENCIES TAGE PREFIX TAGE N 543 A 10 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health selfting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. This RULE is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. This RULE is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse with wounds in 1 of 12 records reviewed (#1). Findings 1. On 7/23/14 at 2 PM, a home visit was conducted on patient 1 with physical therapist, (PT) Employee C. At 2:20 PM, the PT, Employee C indicated the had called the Registered Nurse, (RN) Employee D, on Monday 7/21/14 about the open wound on the patient's right lower leg. The wound was from radiation related to cancer. The patient indicated the patient and applied Silver Sulfadiazine 1%, from the nursing home stays in May, into the wound. The wound was ozong a pink color liquid that had drained approximately 1.5 in chas down the patient's leg and solied the top of the sock.		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER TO SUMMARY STATEMENT OF DEFICIENCIES TO SUMMARY STATEMENT OF DEFICIENCIES (PA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES IE. ELGAL DEFICIENCY MUST SEP PRECEDED BY FULL PREFIX TAG PREFIX TAG N 543 10 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. This RULE is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had initiated interventions to address identified problems with wounds in 1 of 12 records reviewed (#1). Findings 1. On 7/23/14 at 2 PM, a home visit was conducted on patient 1 with physical therapist, (PT) Employee C. At 2-20 PM, the PT. Employee C indicated he had called the Registered Nurse, (RN) Employee D, on Monday 7/21/14 about the open wound on the patient's night tower leg. The wound was from radiation related to cancer. The patient indicated the Raje in is 3-4 on a scale of 1-10 and quite bothersome. The patient indicated the RN, Employee D, and not called the patient nor had made a visit to assess the patient. The wound is approximately 1-5 in x 1-5 and circular in nature, it is impossible to gauge anything else as the patient had applied Silver's Suiladiazine 1%, from the nursing home stay in May, into the wound. The wound was occing a pink color liquid that had drained approximately 1-5 inches down the	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
NAME OF PROVIDER OR SUPPLIER TO SUMMARY STATEMENT OF DEFICIENCIES TO SUMMARY STATEMENT OF DEFICIENCIES (PA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES IE. ELGAL DEFICIENCY MUST SEP PRECEDED BY FULL PREFIX TAG PREFIX TAG N 543 10 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. This RULE is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had initiated interventions to address identified problems with wounds in 1 of 12 records reviewed (#1). Findings 1. On 7/23/14 at 2 PM, a home visit was conducted on patient 1 with physical therapist, (PT) Employee C. At 2-20 PM, the PT. Employee C indicated he had called the Registered Nurse, (RN) Employee D, on Monday 7/21/14 about the open wound on the patient's night tower leg. The wound was from radiation related to cancer. The patient indicated the Raje in is 3-4 on a scale of 1-10 and quite bothersome. The patient indicated the RN, Employee D, and not called the patient nor had made a visit to assess the patient. The wound is approximately 1-5 in x 1-5 and circular in nature, it is impossible to gauge anything else as the patient had applied Silver's Suiladiazine 1%, from the nursing home stay in May, into the wound. The wound was occing a pink color liquid that had drained approximately 1-5 inches down the						
NAME OF PROVIDER OR SUPPLIER TAGE TO A HEALTHTRENDS SUMMARY STATEMENT OF DEFICIENCIES (CA) ID PREFIX (FACIO DEFICIENCY MUST BE PRECEDED BY TUNE TAG N 543 410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. This RULE is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had initiated interventions to address identified problems with wounds in 1 of 12 records reviewed (#1). Findings 1. On 7/23/14 at 2 PM, a home visit was conducted on patient 1 with physical therapist, (PT) Employee C. At 2:20 PM, the PT, Employee C indicated he had called the Registered Nurse, (RN) Employee D. on Monday 7/21/14 about the open wound on the patient's night lower leg. The wound was from radiation related to cancer. The patient indicated the pain is 3-4 on a scale of 1-10 and quite bothersome. The patient indicated the RN, Employee D, and not called the patient nor had made a visit to assess the patient. The wound is approximately 1.5 in x 1.5 and circular in nature. It is impossible to gauge anything else as the patient had applied Silver Sulfadiazine 1%, from the nursing home stay in May, into the wound. The wound was ozong a pink color liquid that had drained approximately 1.5 inches down the			004608	B. WING		07/29/2014
Table Tabl	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS CITY STA	TE ZIP CODE	
(A) ID SUMMARY STATEMENT OF DEPICIENCIES PROFILE IN 46375 (EACH DEPICIENCY AUST OF ERROLLED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 543 410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. This RULE is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had initiated interventions to address identified problems with wounds in 1 of 12 records reviewed (#1). Findings 1. On 7/23/14 at 2 PM, a home visit was conducted on patient 1 with physical therapist, (PT) Employee C. At 2.20 PM, the PT, Employee C indicated he had called the Registered Nurse, (RN) Employee D, on Monday 7/21/14 about the open wound on the patient's right lower leg. The wound was from radiation related to cancer. The patient indicated the pain is 3-4 on a scale of 1-10 and quite bothersome. The patient indicated the Repistered than a proxymately 1-5 in x 1-5 and circular in nature, It is impossible to gauge anything else as the patient had applied Silver Sulfadiazine 1%, from the nursing home stay in May, into the wound. The wound was ozoling a pink color liquid that had drained approximately 1-5 inches down the	TO UNIC OT TH	TO VIDER OR OUT FEEL				
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Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. This RULE is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had initiated interventions to address identified problems with wounds in 1 of 12 records reviewed (#1). Findings 1. On 7/23/14 at 2 PM, a home visit was conducted on patient 1 with physical therapist, (PT) Employee C. At 2:20 PM, the PT, Employee C indicated he had called the Registered Nurse, (RN) Employee D, on Monday 7/21/14 about the open wound on the patient's right lower leg. The wound was from radiation related to cancer. The patient indicated the pain is 3-4 on a scale of 1-10 and quite bothersome. The patient indicated the RN, Employee D, had not called the patient nor had made a visit to assess the patient. The wound is approximately 1.5 in x 1.5 and circular in nature. It is impossible to gauge anything else as the patient had applied Silver Suffadiazine 1%, from the nursing home stay in May, into the wound. The wound was oczing a pink color liquid that darined approximately 1.5 inches down the	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE
are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. This RULE is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had initiated interventions to address identified problems with wounds in 1 of 12 records reviewed (#1). Findings 1. On 7/23/14 at 2 PM, a home visit was conducted on patient 1 with physical therapist, (PT) Employee C. At 2:20 PM, the PT, Employee C indicated he had called the Registered Nurse, (RN) Employee D, on Monday 7/21/14 about the open wound on the patient's right lower leg. The wound was from radiation related to cancer. The patient indicated the pain is 3-4 on a scale of 1-10 and quite bothersome. The patient indicated the RN, Employee D, had not called the patient nor had made a visit to assess the patient. The wound is approximately 1.5 in x 1.5 and circular in nature. It is impossible to gauge anything else as the patient had applied Silver Sulfadiazine 1%, from the nursing home stay in May, into the wound. The wound was oozing a pink color liquid that had drained approximately 1.5 in ches bown the	N 543	410 IAC 17-14-1(a)(1)(D) Scope of Services	N 543		
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D, on Monday 7/21/14 about the open wound on the patient's right lower leg. The wound was from radiation related to cancer. The patient indicated the pain is 3-4 on a scale of 1-10 and quite bothersome. The patient indicated the RN, Employee D, had not called the patient nor had made a visit to assess the patient. The wound is approximately 1.5 in x 1.5 and circular in nature. It is impossible to gauge anything else as the patient had applied Silver Sulfadiazine 1%, from the nursing home stay in May, into the wound. The wound was oozing a pink color liquid that had drained approximately 1.5 inches down the		conducted on patient (PT) Employee C. At 2:20 PM, the I	1 with physical therapist, PT, Employee C indicated he			
The patient indicated the RN. Employee C.		D, on Monday 7/21/14 the patient's right low radiation related to cathe pain is 3-4 on a subothersome. The patemployee D, had not made a visit to assess approximately 1.5 in 2 It is impossible to gaupatient had applied S the nursing home stathe wound was oozind drained approximately patient's leg and soiled	4 about the open wound on er leg. The wound was from ancer. The patient indicated cale of 1-10 and quite tient indicated the RN, called the patient nor had as the patient. The wound is at 1.5 and circular in nature. If you is anything else as the liver Sulfadiazine 1%, from you in May, into the wound. If you is inches down the end the top of the sock.			

Indiana State Department of Health

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NAME OF PROVIDER OR SUPPLIER VNA HEALTHTRENDS SCHERERVILLE, IN 46375 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 732 E US HWY 30 SCHERERVILLE, IN 46375 ID PROVIDER'S PLAN OF CORRECTION	9/2014
VNA HEALTHTRENDS 732 E US HWY 30 SCHERERVILLE, IN 46375 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	
VNA HEALTHTRENDS SCHERERVILLE, IN 46375 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	
(4.1).5	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
nd been informed of a place starting on the left lower leg. The patient indicated the RN had not acted on the information. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had initiated interventions to address identified nursing needs in 1 of 12 records reviewed (#1) creating the potential to affect all of the agency's 204 active patients. Findings 1. On 7/23/14 at 2 PM, a home visit was conducted on patient 1, with physical therapist, (PT) Employee C. At 2.20 PM, the PT, Employee C indicated he had called the Registered Nurse, (RN) Employee D on Monday 7/21/14 about the open wound on the patient's right lower leg. The wound was from radiation related to cancer. The patient, (#1) indicated the patient is 3-4 and quite bothersome. The patient #1, indicated the RN, Employee D had not called the patient nor had made a visit to access the patient. The wound is approximately 1.5 in x 1.5 in circular in nature. It is impossible to gauge anything else as the patient had applied Silver Sulfudiazine 1%, from the nursing home stay in May, into the wound. The wound is oozing a pink color liquid that and had drained approximately 1.5 in down the patient's leg and soiled the top of the sock. The patient indicated the RN, Employee C had been informed of a place starting on the left lower leg. The patient indicated the RN had not acted on the information. 2. On 7/28/14 at 11 AM, Employee D, Registered	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		004608	B. WING		07/2	9/2014
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 0112	3/2014
VNA HEAI	LTHTRENDS	732 E US F SCHERER	IWY 30 VILLE, IN 4637	75		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
N 543	after she was told about left leg due to commit was booked and coul also indicated the pat pending with the onco July 24th. She did not and was waiting for the oncologist. 3. An agency policy the with no date stated, " to comply with governust be a reasonable needs can be met in the Agency's programs and stated and stated are also stated are also stated and stated are also stated are also stated and stated are also stated are also stated and stated are also stated are also stated and stated are also stated and stated are also stated	being able to visit the patient but the new wound on the aments with another job. "I do not go, " she said. She ient had an appointment blogist for wound care on at call the primary physician he patient to see the sernment regulations there are expectation that the client's the home setting through the	N 543			
IN 343	Rule 14 Sec. 1(a) (1)(are limited to therapy practice in the home I nurse shall do the foll (F) Coordinate service. This RULE is not me Based on clinical record and interview, the age personnel communical services to support the 10) of 12 records revious to support the findings include. 1. Clinical record # 7 included a plan of car of 6/21/14 - 8/19/14 woursing, occupational	(F) Except where services only, for purposes of health setting, the registered owing: ess. It as evidenced by: ord and agency policy review ency failed to ensure all ated and coordinated e plan of care in 2 (# 7 and ewed. It is a evidenced by: ord and agency policy review ency failed to ensure all ated and coordinated e plan of care in 2 (# 7 and ewed.	N 949			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	
		004608	B. WING		07	7/29/2014
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE S HWY 30	E, ZIP CODE		
VNA HEA	LTHTRENDS	SCHERI	ERVILLE, IN 46375	(
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)		COMPLETE
N 545	any coordination of courses services to supcare. Skilled nursing 6/25/14, 7/1/14, 7/4/7 7/22/14. Occupation 6/27/14, 7/9/14, 7/9/14, 7/9/14, 7/9/14, 7/9/14, 7/9/14, 7/9/14, 7/9/14, 7/9/14, 7/9/14, 7/9/14, 7/9/14, 7/9/14 and 7/18/14. On 7/28/14 at 12 president of operation coordination of care coordination of care caring for the patient. 2. Clinical record #1/1/10/14 included a plan of care of 5/3/14 - 7/1/14 with therapy and physical documentation to should an occupational the and coordinated services plan of care. Physica 5/3/14, 5/8/14, 5/14/10/15/31/14. On 7/28 at 4:50 there was no coordinated services caring for the services caring for the services caring for the services caring for the cassigned to coordinated services caring for the services communicated services caring for the services caring for the care team's communicated services caring for the services caring for the cassigned to coordinated services caring for the case of th	are had occurred between oport the patient's plan of visits were on 6/21/14, 14, 7/8/14, 7/15/14, and all therapy visits were on 1/4, 7/18/14, and 7/19/14. Its were on 7/23/14, 6/25/14, 14, 7/11/14, 7/15/14, 7/16/14, 15/30 PM, Employee B, vice in s, indicated there was no between these services on the certification period in orders for occupational therapy. There was no ow that the physical therapist rapist had communicated vices to support the patient's all therapy visits occurred on 1/4, 5/17/14, 5/24/14. Its visits occurred on 5/9/14, 9/14, 5/22/14, 5/30/14, and PM, Employee B indicated ation of care between the	N 545			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED								
004608 B. WING 07/29/20	07/29/2014							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
VNA HEALTHTRENDS 732 E US HWY 30 SCHERERVILLE, IN 46375								
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE							
N 545 Continued From page 25 to facilitate continuity of care; to assure appropriate care."								

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